Published in final edited form as:

J Aging Stud. 2015 January ; 32: 12–22. doi:10.1016/j.jaging.2014.12.001.

Gendered emotion work around physical health problems in mid- and later-life marriages[☆]

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Abstract

The provision and receipt of emotion work—defined as intentional activities done to promote another's emotional well-being—are central dimensions of marriage. However, emotion work in response to physical health problems is a largely unexplored, yet likely important, aspect of the marital experience. We analyze dyadic in-depth interviews with husbands and wives in 21 mid-to-later-life couples to examine the ways that health-impaired people and their spouses provide, interpret, and explain emotion work. Because physical health problems, emotion work, and marital dynamics are gendered, we consider how these processes differ for women and men. We find that wives provide emotion work regardless of their own health status. Husbands provide emotion work less consistently, typically only when the husbands see themselves as their wife's primary source of stability or when the husbands view their marriage as balanced. Notions of traditional masculinity preclude some husbands from providing emotion work even when their wife is health-impaired. This study articulates emotion work around physical health problems as one factor that sustains and exacerbates gender inequalities in marriage with implications for emotional and physical well-being.

Keywords

Emotion work; Gender; Marriage; Physical health problems

Emotion work—activities done with the intention of promoting another's positive emotional state—is conceptualized as part of the division of unpaid household work commonly done

[☆]This research was supported in part by grant R01 AG17455 (Principal Investigator, Debra Umberson) from the National Institute on Aging and a training grant in population studies (5 T32 HD007081) as well as a center grant (R24 HD042849; PI: Mark Hayward) from the National Institute of Child Health and Human Development to the Population Research Center at the University of Texas at Austin.

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within marriage (Eichler & Albanese, 2007; Erickson, 2005; Hochschild, 1979, 2003; Pfeffer, 2010). Much like other forms of unpaid work, the division of emotion work is highly gendered wherein women do a disproportionate share of emotion work relative to men (Erickson, 2005; Hochschild, 2003; Umberson, Thomeer, & Lodge, 2015). Previous research suggests that emotion work is especially present within marriage during times of high stress (Erickson, 2005; Pfeffer, 2010), and one of the most pervasive stressor in mid- and later-life occurs when one or both spouses have physical health problems (Taylor & Aspinwall, 1996). Emotion work done in the context of physical health problems is an especially important consideration in mid- to later-life as physical health problems often emerge or worsen at this life stage (Hung, Ross, Boockvar, & Siu, 2011; Ward, 2013), likely eliciting heightened expectations for emotion work from spouses. We expect emotion work dynamics in the context of physical health problems to be gendered as physical health problems have been shown to alter gender divisions in other types of unpaid work (e.g., caregiving, housework; Allen & Webster, 2001; Pinquart & Sorensen, 2006).

Most studies that examine emotion work or physical health problems in marriage focus on either the health-impaired person¹ or her or his spouse (Allen & Webster, 2001; Gove, 1984; Russell, 2001). However, individual-level approaches provide only one spouse's perceptions of emotion work and physical health problems, overlooking the inherent dyadic dimensions of physical health problems in marriage (Hepburn et al., 2002; Kirsi, Hervonen, & Jylhä, 2000). For example, studies of health-impaired people identify how physical health problems challenge the gender identity of the health-impaired person (Pudrovskaya, 2010; Wall & Kristjanson, 2005), while studies of people with a health-impaired spouse identify how gender inequalities are often produced and reproduced through care work (Calasanti & Bowen, 2006; Russell, 2001). Because gender and marital practices are co-constructed, negotiated, and enacted relationally by both husbands and wives (Chappell & Kuehne, 1998; Seymour-Smith & Wetherell, 2006), we argue that it is critical to use dyadic methods to examine the gendered ways that spouses provide and explain their emotion work, as well as the degree to which husbands and wives agree on these accounts. In this study, we use dyadic qualitative methods to examine how mid- to later-life husbands and wives in long-term heterosexual marriage conceptualize their own—or their spouse's—emotion work during periods of their own—or their spouse's—physical health problems. Specifically, we ask:

1. Who is described as doing or not doing emotion work in response to physical health problems?
2. How do spouses explain the provision or lack of provision of emotion work?
3. How are these explanations different for husbands compared to wives?

In addressing these questions, this study provides new insight into the ways in which emotion work, physical health processes, and marriage are interactive or contested as individuals age.

¹For ease of reading, respondents currently experiencing physical health problems are generally referred to as “health-impaired people”; spouses are referred to as “health-impaired people's spouses.”

Theoretical background

Spouses are at the front line when physical health problems strike. However, how heterosexual married adults respond to their own or their spouse's physical health problems (e.g., whether or not they provide caregiving, how distressed they become) may be related to gendered constructions of being a husband or wife. To understand these dynamics, we draw on a gender relations framework which suggests that masculinities and femininities must be understood in relation to each other (Connell, 2005; Schippers, 2007). In this perspective, hegemonic masculinity, the culturally defined ideal of how men should behave, is defined in opposition to emphasized femininity, the expectation that women should accommodate to men's interests and desires (Connell & Messerschmidt, 2005). In heterosexual marriage, masculinities and femininities are typically seen as exclusive and oppositional, borne out of a strict gender binary imbued with essentializing personality attributes specific to each gender (Ferree, 2010).

Socially constructed gender differences within marriage contribute to disparities in emotion work (Erickson, 2005; Pfeffer, 2010; Umberson et al., 2015). Emotion work was first conceptualized by Arlie Hochschild (2003) as a component of both paid work outside the home (i.e., emotional labor) and unpaid work in the home (i.e., emotion work). Emotion work involves efforts to promote the emotional well-being of others, often through the suppression and regulation of one's own emotions (Hochschild, 1979). Alongside other forms of unpaid work, including childcare and housework, emotion work is more often done by women compared to men and is often unacknowledged and invisible (Eichler & Albanese, 2007; Erickson, 2005). Emotion work can be a source of stress, particularly when it is unreciprocated and unappreciated and when it involves suppressing one's own emotions (Umberson et al., 2015). For example, a person may act upbeat and happy while hiding his/her true feelings of anxiety and worry over a spouse's depression in an effort to improve the spouse's psychological state; this process may create stress and anxiety by increasing a sense of responsibility for the emotion worker (Thomeer, Umberson, & Pudrovska, 2013).

Spouses attribute gender differences in emotion work to the social understanding that women are more "naturally" adept at reading and tending to emotions contrasted with men as rational problem-solvers with high agency (Thomeer et al., 2013; Ussher & Sandoval, 2008). Inequality in emotion work is also linked to the expectation of emotion work as a natural component of wifehood, drawing on constructions of "intensive mothering" and "self-silencing" which dictate that women should nurture and support others by obscuring their own emotional distress (Hays, 1996; Jack, 1993). These gendered notions produce a false dichotomy between the emotional and the rational while devaluing the emotional and contribute to a dualistic structure of gender within marriage (Calasanti, 2004; Cheng, 2008).

We argue that gender inequality around emotion work is especially important to consider during periods of physical health problems. Gender scholars suggest that the meanings of being a husband include the belief that men are not naturally disposed to understanding emotions or being emotional but rather are able to maintain emotional control and rationality; aging scholars also find this to generally be the expectation for older men (Bennett, 2007; Thompson, 2002). This expectation may shift during physical health

problems, especially when men are involved in caregiving; studies find that men do provide care for health-impaired spouses, perhaps as much as women do (Allen & Webster, 2001; Hepburn et al., 2002; Pinquart & Sorensen, 2006). Past research reports that caregiving men are rarely understood (or understand themselves) as emotionally nurturing, yet these studies do not examine men's provision of emotion work in the context of their or their spouse's physical health problems (Calasanti, 2004; Calasanti & Bowen, 2006). Previous research has not considered whether or how emotion work is linked to physical health problems in marriage.

Gendered emotion work dynamics in the context of marriage and physical health problems are especially important to consider among aging adults. It may be that mid- to later-life adults, compared to younger adults, have more traditional and dichotomized ideas about gender differences (Brewster & Padavic, 2000; Davis & Greenstein, 2009). Therefore, mid- to later-life adults may have particularly unequal divisions of emotion work during times of physical health problems, with wives providing more emotion work. In contrast, it may be that the intrusion of physical health problems into a marriage, which is very common among mid-to later-life couples (Ward, 2013), weakens these traditional gender dynamics and promotes gender egalitarianism. This phenomenon is known as "degendering" (Silver, 2003). Degendering may be especially relevant among mid- and later-life men because they do more caregiving than younger men (King & Calasanti, 2013) and because mid- and later-life men who experience their own physical health problems are less likely than men without physical health problems to conform to traditional masculinity scripts (Pudrovska, 2010).

Taken together, previous research suggests that emotion work directed toward enhancing a spouse's emotional well-being is gendered, in terms of both the division of emotion work and explanations for emotion work provision. Yet research has not determined whether these gendered dimensions of emotion work occur during periods of physical health problems, nor how they are understood by husbands and wives themselves. We draw on past work on gender, emotion work, and physical health problems to frame an analysis of gendered dynamics around emotion work and physical illness within mid- and later-life heterosexual marriages.

Methodology

The sample for this analysis was drawn from the Marital Quality over the Life Course study which involved in-depth interviews with 30 married couples (60 individuals) who had been together 7 years or longer. Respondents were recruited in a large southwestern city. Most respondents were recruited through a local newspaper article written about the research study. Additional respondents were recruited through referrals from participants. All respondents were screened by phone prior to enrollment in order to obtain income and marital quality diversity. Of the initial 30 married couples interviewed, at least one spouse in 21 couples discussed having a physical health problem; these 42 individuals in 21 couples comprise the sub-sample used for the present study.

Interview protocol

Interviews were conducted from 2003 to 2004 by the second and third authors and a research assistant. Interviews were tape recorded and transcribed. Pseudonyms were assigned to protect confidentiality. Each spouse was interviewed separately to preserve individual perspectives and provide a comfortable environment to discuss sensitive topics (e.g., feelings around health problems, marital conflict; Reczek, 2014). The interviews lasted 1.5 to 2.5 hours and typically occurred in respondents' homes. Interviews were semi-structured and retrospective, consisting of questions on a number of topics related to marital dynamics and health throughout the relationship. Interviewees were asked to describe major life events that occurred during their marriage and were asked specifically, "Have you or your spouse ever had a significant period of physical health problems?" Interviewees gave a narrative of physical health problems in response to questions that included, "How did the [specific physical health problem] affect you?", "How did it affect your spouse?" and "How did it affect your relationship?" Interviewees who did not discuss their or their spouse's emotional response to the physical health problem were prompted to discuss this. Additionally, interviewees were asked, "Do you ever try to affect your spouse's emotions or feeling about herself/himself?" and "Does your spouse ever try to affect your emotions?" with open-ended follow-up questions.

Analytical sample composition

The majority of respondents analyzed in this subsample identified as White (36), four as Black, one as Asian-American, and one as multiracial. The average education level was about 15 years, and the average household income was \$55,900. The average marital duration was 27.0 years (range: 8–51), and the average age was 55.8 years (range: 30–87). Of the 21 couples who reported a health problem, 2 mentioned a husband's physical health problem (with no mention of a wife's health problem), 5 mentioned a wife's health problem (with no mention of a husband's health problem), and 14 mentioned health problem for both spouses. By comparison, the 10 couples (excluded from the analysis) who did not mention any health problems were 47.2 years on average (range: 30–69) and married for 24.2 years (range: 8–46). Because they were not asked the same follow-up questions as the couples with physical health problems we were not able to include them in this analysis as a comparison group. Socio-demographic information and pseudonyms for each of the 21 couples included in the analytic sample are shown in Appendix A.

Data analysis

We analyzed and coded interview data using Charmaz's (2006) qualitative analysis approach. This approach emphasizes the construction of codes for the development of analytical, theoretical, and abstractive interpretations of the data. Our coding categories were not predetermined; rather, they emerged from systematic analysis of the participants' interviews. We used a multi-staged standardized approach, primarily guided by inductive reasoning. Because this analysis focused on emotion work processes, we used a theoretical understanding of emotion work developed from previous literature to guide our coding of emotion work. We defined emotion work as intentional activities perceived by respondents as requiring effort and done to promote another's emotional well-being. Most often, emotion

work was discussed in response to questions regarding whether respondents had ever tried to influence their spouse's emotions or if their spouse ever did this for them. We coded emotion work as occurring when respondents described themselves or their spouse as intentionally monitoring the other spouse's emotions, trying to improve their spouse's emotions through a variety of tactics (e.g., buying ice cream, talking about feelings, giving compliments), or masking their own negative emotions and stress levels so as to not hurt the other spouse. For the purposes of this study, we only coded responses as emotion work if specifically discussed as provided in response to stress or negative emotions from physical health problems.

In the first stage of analysis, all three authors carefully read through the transcripts and field notes several times to become familiar with the content of each interview. All three authors independently extracted passages that discussed physical health problems and emotion work (or that mentioned absence of emotion work) around those physical health problems. Each author evaluated the initial line-by-line coding for inter-coder reliability, finding agreement between authors. All three authors then developed a standardized codebook from this initial coding and used this codebook for subsequent data analysis. In the second stage, the first author examined how the codes related to one another on a conceptual level. This involved evaluating how interviewees understood their physical health problems as affecting, or not affecting, their own and their spouse's emotion work or lack of emotion work and how respondents explained their and their spouse's emotion work or lack of emotion work. The first author examined patterns in the data across the full sample and discussed these conceptual associations with the other authors. In the final stage, the first author identified gender differences in the codes. The first author also tested for age differences but found none.

Our dyadic interview design allowed us to focus on the contrasts and overlaps between spouses' versions of and ascribed meanings to similar events (Chappell & Kuehne, 1998; Eisikovits & Koren, 2010), and the first author analyzed interviews with attention to these dyadic patterns. Themes and subthemes were developed from the codes, and all three authors discussed and agreed on these themes. We provide quotes below which are illustrative of each recurring theme. We achieved theoretical saturation once no new themes regarding emotion work and physical health problems emerged and when existing themes had sufficient data (Charmaz, 2006). Analysis was done with the aid of QSR International's NVivo 9.

Results

In this study we examined gendered emotion work in response to physical health problems in heterosexual mid- to later-life marriages. Analyses revealed that both men and women described themselves, and were described by their spouse, as providing emotion work; both men and women also offered explanations for their and their spouse's emotion work. In addition, analyses revealed that men, but not women, described themselves (and were described by their spouse as) explicitly *not* providing emotion work.

Husbands' emotion work for their health-impaired wife

Ten of nineteen men married to a health-impaired woman were described as occasionally doing emotion work. As one illustration of this theme, when Gwen had brain cancer, her husband Hal noticed that she was upset after treatments. Hal said that he worked to alleviate Gwen's distress:

When she was going through those bouts of depression or when she was fresh out of the hospital, I tended to do more in terms of...supporting her in doing the things that she loves to do.

Gwen similarly discussed the mental energy that Hal put into observing and caring for her emotions during this time. For example, after she began anti-depressants after diagnosed with osteoporosis, she recalls Hal being worried for her and sitting her down to say, "I just don't want you to lose hope. I feel like you've lost hope." Gwen said this encouragement from Hal "just turned me around."

Changes in husbands' emotion work

While half of men and women described men providing emotion work at some point for health-impaired women, the majority of men and women also talked about times that the husband *did not* provide emotion work. For four of the couples, this apparent contradiction occurred because wives experienced multiple physical health problems at different points in time; sometimes husbands did provide emotion work and at other times they noticeably did not provide emotion work. Katherine had two mastectomies. After the first, Bill was frustrated because he said he did not feel he was emotionally caring for her like she wanted: "I was really in agony because I felt like I couldn't really give her the kind of support that I needed to be able to." Katherine echoed these frustrations, stating that Bill was shut down emotionally and did not help her during this time. But after her second mastectomy, Bill and Katherine both said that Bill provided emotion work, largely due to active coaching on Katherine's part. Bill explained that he provided emotion work by "mainly trying to keep the stress off of her. And things that I know are stressing her." Tonya suffered from asthma and had multiple asthma attacks. Her husband, Aubrey, initially was not good at helping her through the anxiety she would feel after and during these attacks, but over time he felt he had improved, saying he was now "trying to focus more on her and her needs. And not just selfish desires of mine."

Husbands' lack of emotion work for their health-impaired wife

Seven husbands described themselves or were described by their wife as never providing emotion work for their health-impaired wife. Some of these men described themselves and were described by their wives as failing to control their emotions around their wife and consequently causing stress for their health-impaired wife. Controlling and even concealing negative emotions are a key element of emotion work, as originally described by Hochschild (1979). Many of these husbands still provided important physical and instrumental caregiving (e.g., helping spouse in and out of bed), but notably neglected to perform emotion work. Bruce's wife Carrie received brain surgery. Although he tried to control her

physical environment to protect her during this complicated procedure, he did this without attending to her emotional well-being:

When I was down at the hospital, I griped everybody out. I was in a tirade... She later said to me that I did a crummy job. I was crying with frustration... So, I raised quite a storm. She didn't like that... She told me I should have just stayed in there with her. I was just so mad. I was mad at the whole world.

Carrie cried during her interview when discussing Bruce's disruptive behavior at the hospital:

It made me feel very bad because the doctor did come out and say, 'You should tell your husband I'm here to do everything for your good and he shouldn't be doing this.'... And I had an older woman in the same room and she was saying, you know, 'Bruce, you shouldn't do this to her.'

By failing to conceal their own worry and negative emotions like anger, Bruce and other husbands did not provide emotion work for their health-impaired wife and instead caused their wife distress.

In addition to not controlling their emotions and subsequently contributed to their wife's distress, both men and women noted times when men did not take any action to try to improve their wife's negative emotional state. Bruce said when Carrie was worried about her surgery, he thought, "She just has to snap out of it. Just get over it," and he did not try to help her. Nina was asthmatic and attributed the 100 lb she gained during her marriage to Lloyd to the steroids she had to take to control her asthma. But she said that rather than helping her feel okay about her weight gain, Lloyd said statements like, "Boy you are big." and "You are really fat." She said of these statements, "Well, sometimes I feel pretty bad. And sometimes I feel pretty angry." She believed his statements (and lack of emotion work around this area) contributed to her depression.

Discrepancies in accounts of husbands' emotion work

In three couples, husbands and wives provided discordant accounts of husbands' emotion work provision toward their health-impaired wife. Rick, whose wife Janna had Parkinson's disease, explained, "On the one hand, I take care of her, but on the other hand, I don't do as good a job of adjusting to her emotional needs." Janna's interpretation is different, describing how Rick comforted her when she was emotionally distressed because of her Parkinson's disease:

I have cried on his pillow and in his arms many nights. Because by nighttime I would be so frustrated, so tired... He doesn't have magic words to say, but I don't require magic words.

Similarly, Joel noted that he felt incapable of understanding Sasha's emotional needs in relation to her heart problems and said, "I got to kind of just watch and let her figure it out." Yet Sasha reported that Joel did in fact provide emotion work: "He just comforts me... he says, 'You are going to be fine.' ... He is very good for me.... he calms me greatly." Contradictory accounts indicate that these husbands and wives were not drawing on analogous gendered discourses to understand husbands' (lack of) emotion work.

Explanations for husbands' emotion work

Above we described accounts of whether husbands did or did not do emotion work for their health-impaired wife. Women and men in our study also explained why they thought husbands did or did not provide emotion work in these circumstances. Scholars suggest men and women in heterosexual marriage co-construct and articulate “gender strategies” and “family myths” to explain unequal divisions of unpaid work, including emotion work (Hochschild & Machung, 1989; Pfeffer, 2010). These explanations serve to maintain current arrangements of who does and does not provide unpaid work in the home while avoiding conflict over unfairness. In our analysis, wives and husbands rarely discussed gender as a concept directly. However, their explanations nevertheless operated as gender strategies and family myths that drew on socially constructed understandings of the meanings of man/husband and woman/wife.

Explanations for husbands doing emotion work

Men used two primary reasons to explain why they provided emotion work for their health-impaired wives: *being a rock* and *marriage as balanced*. The explanation that the husband was the rock of the marriage and thus provided emotion work for his health-impaired wife fit within an understanding of husbands' masculinity, building on a view of men as the source of stability and security for their wife. Valerie liked to be active, so when she broke her ankle and was on bed rest her husband Keith feared that she may become depressed and not eat, as she had done in the past. She explained, “When I get sick or when I am on bed rest and stuff, he always made sure I ate. Because I would just not eat.” In this way, Keith looked after her physical health and her emotions. He explained that he did this because, “I can be you know, we'll say the rock or an anchor that if she drifts too far, is always something holding her to come back.” This explanation of husbands as a source of strength and stability was also deployed by some women when explaining why their husbands successfully provided emotion work. Gwen said, “What I can do with my husband is depend on him to be there for me, whenever I need.” Angie, who felt her husband Brett did a lot of emotion work for her during her numerous health problems, said she believed he did this because being a husband means “being there for your wife” and providing stability.

Second, men provided emotion work in order to keep the marriage balanced. Men who used this explanation said that they did emotion work for their health-impaired wife because their wife did (or would do) emotion work when the husbands were health-impaired. In this way, wives taught husbands how to provide emotion work, largely by modeling this emotion work. Husbands tended to see emotion work as a skill to use only during periods of physical health problems. Malcolm explained why he did emotion work for his wife, Doris, as she dealt with her many health problems:

Her mobility is impaired. And that makes one short tempered. And I take some of the brunt of that and take it philosophically and say it is probably what I would do if our roles were reversed.

Malcolm had not yet experienced a serious physical health problem or mobile impairment, yet he believed his wife would do emotion work for him if this occurred and thus he did

emotion work for her when she was ill. At the same time, as discussed below, Malcolm struggled with doing emotion work and thought he was often unsuccessful.

At different points in Gwen and Hal's marriage, each spouse was diagnosed with cancer and each underwent chemotherapy. Both spouses described that when Hal had cancer, Gwen provided emotion work for him; during Gwen's cancer, Hal provided emotion work for her. Notably, though, Gwen and Hal both said he struggled with providing emotion work early in her illness but over time he said he learned his emotion work was necessary for balance in their marriage:

It's very much a give and take, even keel, shared experience...Because we've taken turns being patient and care-giver, it's been a real challenge to maintain that balance at times because we have each had to, in turn, heavily lean on the other person. But, in that, we have found a better understanding about what the balance means, that it's not about being independent and together, it's more a sense of, I guess, interdependence is the word that fits our understanding of what that balance is about.

Yet, despite the explicit discussion of balance, according to most husbands' and wives' accounts, the provision of emotion work was not described as equal. For example, for Gwen and Hal, Gwen provided emotion work at all times, even when health-impaired (discussed below), but Hal did this emotion work for Gwen only when she had cancer. In this way, Gwen and other health-impaired wives' emotion work during their own physical health problems was overlooked, and the idea of marriage as balanced operated as a family myth, obscuring the gender inequality around emotion work that was occurring during health impairments. By drawing on an understanding of balance as intrinsic to their marriage, men referenced their identity as husband, thus protecting their own masculine identity while simultaneously providing emotion work.

Explanations for men not doing emotion work

Men (and some women) utilized three main discourses to explain why husbands did not provide emotion work: *husbands do not perceive wives' emotions*, *husbands are the protectors*, and *husbands are the problem-solvers*.

Just as previous research shows that men explain that they do not do housework because they do not notice whether or not it is done (Dempsey, 1999; Miller & Sassler, 2012), six men in our study said that they did not do emotion work for their wives because they did not see or understand their wives' emotions. Jake justified not doing emotion work for his wife Louise when she had her wisdom teeth removed by saying, "If it had been me, I would have laid there and suffered and not cared if anybody cared." Because he understood himself as not being emotional about his own physical health problems, he assumed the same of his wife. Malcolm felt that he did not know how to pay attention to his wife's emotions, "I think it is the Mars, Venus thing where I tend to view things rationally... I don't know how to deal really with emotional problems." Malcolm emphasized that he was the rational one, distinct from his wife, by explicitly linking his marriage to the popular discourse that "Men are from Mars and women are from Venus" (Gray, 1993). Rick drew on this same popular discourse,

saying, “I guess I am too much on Mars...And a lot of times I probably overlook the way she is feeling.” The “men are from Mars, women are from Venus” discourse emphasizes that men are rational and women emotional and that these categories are mutually exclusive. This dichotomous understanding of men and women in regard to emotions was not shared by women with a health-impaired spouse, as wives described themselves as both solving their husbands’ health-related physical problems and emotionally caring for their husband.

Findings further revealed that eight men in our study described themselves (and/or were described by their wife) as protectors and six men described themselves as problem-solvers in relation to their wife’s physical health problems. These labels are in line with traditional gendered beliefs that position husbands as breadwinners, family leaders, and physical and financial protectors of the home and family (Rosin, 2012). Just as men in previous studies explain not doing housework by arguing that their position as breadwinner is not in line with domestic work (Dempsey, 1999; Hochschild & Machung, 1989), we found that our male respondents explained their lack of emotion work by emphasizing their protecting and problem-solving attributes in the stead of emotions. Strength and rationality were described by these men as helpful for physical and instrumental caregiving but as preventing emotion work. Husbands who did not provide emotion work used a language of difference to delineate who husbands and who wives were even during periods of physical health problems.

Several husbands saw themselves as protectors of wives’ physical health, yet this did not extend to doing emotion work to protect women’s emotional well-being. Malcolm said of Doris who had arthritis, “Since she is physically failing, I have a very strongly protective role now.” This protective role was seen by men as allowing the provision of physical care but contributing to the overlooking of emotions. This physical care was sometimes overbearing, as husbands who saw themselves as protectors framed their wife as someone who needed protection in line with cultural constructions of women as the weaker gender (Bullough, Shelton, & Slavin, 2004). Bruce, who understood himself as incompetent at providing emotion work and only able to respond to his wife’s physical needs, described his wife as “real strong all the time” but after her brain surgery “she was very, very fragile.”

Notably, husbands and wives in our sample were often in disagreement with each other in this construction of women as weak. Many wives who were seen by their husbands as needing a protector did not share this view; these women experienced unanticipated tension because of this protector/protected dynamic. Doris said she was frustrated with how Malcolm tried to care for her because “his solicitation was overbearing” and caused her more stress. Barbara was partially paralyzed and said, “I am so independent that it has been real hard on me to be dependent on [my husband], because I have never been dependent on him before.” Her husband, Lou, saw this as positive and as drawing them closer to each other. By viewing their own care work as protective and focusing on the physical aspects of caregiving, these eight husbands overlooked the emotional discomfort this caused for their wife—in turn exacerbating their wife’s emotional distress.

A third way men justified not providing emotion work was by deploying notions of themselves as problem-solvers. Previous research finds that many men married to a health-

impaired woman conceptualized caregiving as a series of problems to master (Ussher & Sandoval, 2008); yet we add an important caveat that a wife's emotional distress was rarely described by men as a problem to solve. Men in our study described themselves as inept at understanding or fixing emotional problems and thus unable to do emotion work. Key to this idea was the construction of two dichotomies—emotional problems and physical problems as opposite and exclusionary and problem-solving and emotion work as distinct and mutually exclusive. Such understandings were embedded within a gender binary within marriage of false dichotomies of husbands as rational and wives as emotional. Joel explained why he was incapable of understanding his wife's emotional needs: "I'm an engineer so I fix things. So I just got to say, 'Well, you need to do this. You need to do this and fix these things.' And she doesn't want anybody to fix it." Rick said that when he tried to help his wife:

I focus on taking care of doing what I can, to get her well. To get her to the doctor. To take care of things that would make her feel better physically and so forth...So immediately I start, okay here is the problem. Okay, one way we can get around this is this. You know. And I am focused on how to overcome the impediment. She stops me and says, "You are not hearing me."

In general, women did not as strongly acknowledge the dichotomy of emotionality and rationality and were more likely to see the two as compatible. Some wives rejected a strictly gendered emotion work binary and expected husbands to provide emotion work. Sasha and Janna, for example, whose husbands—Joel and Rick—were discussed above, did not view their husbands as problem-solvers at the exclusion of providing emotion work. Instead, they saw their husband as their rock and support and therefore interpreted their husband's behavior as emotion work. However, Rick, Joel, and other men drew on the belief that problem-solving and emotion work were in opposition, wherein men were only capable of problem-solving, not emotion work.

Wives' emotion work for their health-impaired and non-health-impaired husband

Men's emotion work was only discussed when their wife was health-impaired; however, women's emotion work was discussed in instances when either they or their spouse was health-impaired. Husbands and wives were in general agreement about the emotion work provided by wives. Harold described how his wife Mary helped him stay calm while he dealt with his diabetes' diagnosis: "The stress level is down because you know [my] situation, yeah it is bad, but it is not as bad as it could be. You get reminded of things that are more to the positive, at least I do, from Mary." Mary said that one way she looked after her husband's emotions was by trying to make his diabetes require less of an adjustment. She said, "Well first they told him his diet would have to change and obviously and I said, 'Well I found a recipe for a pie crust that can be made – he liked desserts with every meal – a pie crust that can be made with coconut instead of flour.'" This helped Harold control and cope with his diabetes. After Bill had bypass surgery, he said he "was having trouble dealing with everything." To help him, his wife Katherine said she was "always trying to make him feel better about himself." One way he described that she did this was by monitoring his activities and taking over if she felt he was too tired. He said, "She perceived that I was too

tired...I really do enjoy the situation when that comes up [and she says], ‘You are too tired to do that now.’”

Some women such as Mary found that providing emotion work for their husband when their husband was health-impaired was especially difficult because their husband did not recognize or respond to her emotional needs. Harold said when he was hospitalized for his diabetes, “I had a really negative and bad attitude. People come to visit me in the hospital and then they wondered why they came...I wasn’t being nice.” Both Mary and Harold discussed the stress this caused for her. Nina similarly described that providing emotion work for her husband was especially difficult because, “He gets more angry now that he is sicker. And the sicker he gets, the more angry he gets.”

In contrast, many of the health-impaired women worked to provide emotion work for their husband to ease his caregiving tasks. Seven women provided emotion work when they were health-impaired. While Hal provided emotion work for Gwen during her brain cancer treatment, Gwen also engaged in emotion work when she noticed Hal was stressed from caring for her. Gwen said when Hal “got weary and he needed a break,” she encouraged him to “take [a break] and he went away for two weeks” while Gwen was cared for by her sister. Hal noted that Gwen gave him emotional breaks and reliefs regularly when she was health-impaired, explaining, “There are times when I just need time out, I just need space. Like I mentioned, when I come home from work all day...sometimes I just don’t want to talk for a little while. So, uh, and she’s very good at saying, ‘Well, if you don’t want to talk, can I just rub your feet for you?’ ‘Oh, okay!’” Barbara, who was partially paralyzed, hid the extent of her pain from her husband Lou and tried not to complain, saying if she did otherwise, “It upsets him. I don’t want to upset him.” When Lou was asked how Barbara reacted to being partially paralyzed, he said, “I don’t know how it affected her,” suggesting that Barbara’s efforts to mask her feelings from Lou were successful.

Explanations for wives’ emotion work

Women and men drew on two dominant frames to explain why wives provide emotion work continuously regardless of health status: *emotion work as natural for women* and *men need emotion work*. Many men and women did not offer any explanation for why wives provide emotion work, perhaps because they considered emotion work as a natural dimension of being a wife and thus did not see this as noteworthy. The idea that women’s emotion work was natural was described by five wives and three husbands. This was consistent with gendered expectations of women as emotion experts and contrasts understandings of men as not emotionally adept. During Robert’s surgery, Kinsey said she worked to “meet his needs and make sure that his nursing care was good, that he wasn’t in any pain.” She described her active monitoring of Robert’s emotions as well as her actions to improve his emotions and alleviate his pain as routine: “you know, just typical of me.” Nina was married to Lloyd, who was considerably older than her and had a number of physical health problems. Nina cared for Lloyd in a number of ways, including doing household chores, reminding him to take his medicine, and helping him with his physical therapy. She also identified that part of her work was caring for him emotionally. She said she did this because it was “what Lloyd expects of me. He expects of me to be his leaning post.” This expectation was reasonable,

she said, because, “I am good at it.” The provision of emotion work by Nina and other women was viewed as typical and natural and thus expected and not seen as particularly noteworthy by the women themselves or their husband.

Women who provided emotion work for their health-impaired husbands were sometimes described as acting like a nurse or having nurse-like characteristics or skills; yet none of the women in our study who were described as nurse-like had worked in a medical field. Wendell said of the emotion work that Helen did for him: “She turned out to be a nurse.” In contrast, these were labels that men avoided, as Malcolm said that though he looked after Doris because of her arthritis, he did not “mean to imply that I was her nursemaid.” This highlights that a key part of the enactment of hegemonic masculinity within marriage involved relationally contrasting it to emphasized femininity and wifehood (Connell & Messerschmidt, 2005).

The “natural” provision of emotion work by women was further linked to the relationship between womanhood and motherhood. Lou described Barbara as “like an old mother hen.” When Jake was in the hospital with a collapsed lung, Louise felt strongly about helping him emotionally, in part because this responsibility was passed from Jake’s mother to Louise at his mother’s death. Louise noted that in their final conversation she told Jake’s mother, “I will take care of Jake. And you don’t have to worry about him,” saying “the responsibility of looking after [Jake] was passed from [Jake’s mother] to me.” Motherhood and wifehood mutually involved the socially constructed broader (emotion) work of women.

As a related theme, four women in our study explained that they did emotion work for their husbands when they or their husband was health impaired because they thought their husband needed it. This theme, in contrast to the *emotion work as natural for women* explanation, emphasized characteristics of the husband rather than characteristics of the wife. As seen above, Jake and other men were cast as the person in need of emotion work in all circumstances—health-impaired or not. Just as it was seen as natural for wives to provide emotion work, wives saw it as natural for husbands to receive it. Kinsey described a series of her health problems, including a mastectomy and two instances of heart trouble which eventually necessitated a pacemaker. During that time she viewed her husband as emotionally weak and felt she needed to hide the extent of her illness from him: “I heard from my sister that he was really worried and you know he kind of...I could see that if I was sick, he would kind of come unglued.” She decided to convince him, no matter how she was feeling, that she was, “On top and healthy,” saying, “It makes me adore him also that I am so important to him that if something happened to me he would just—I don’t know that he could make it, you know.”

Consequences of wives’ emotion work

The construction of women as natural carers often had negative consequences for wives, especially when chronic conditions were present. Kinsey said she found the emotion work she did for her husband “exhausting sometimes. And then every so often I will snap like I did the other day. Like, ‘I can’t do this anymore. You are asking me something I can’t do.’ You know, because I do it all the time.” Wives also said that emotion work felt stressful

when this construction of caring as natural did not align with their self-perceptions. When Jake was in the hospital, Louise felt responsible, albeit inadequate, to help Jake cope.

I had to take care of him. He was in the hospital so we had medical people taking care of him, but I needed to be sort of a caregiving person... And I don't know how to make people feel comfortable and better and I felt sort of stressed... And it made me uncomfortable.

Louise demonstrated the “dark side” of caregiving and emotion work, where wives’ emotional and physical well-being were often overlooked. This dynamic is heightened when coupled with the finding that husbands did not seem to provide emotion work when health-impaired. Even though Louise said she felt she failed at providing an adequate amount of emotion work for Jake while he was hospitalized, in general during health impairments, she did monitor his emotions and attempted daily to improve his mood:

I know by the way he is breathing in the morning if he is going to wake up and have good day or a bad day. I can tell from whether he has called me or not if he is stressed and having a stressful day or not. I can tell from the way he talks to somebody else if he is normal, if he is having a good time or a bad time.

Even amidst a regular effort to provide emotion work, Louise’s discomfort at her perceived failure demonstrated women’s high standard of emotion work. This self-imposed high standard was often described as detrimental to women’s own emotional well-being.

Discussion

By using a dyadic approach and drawing on a gender relations framework, our analysis extends understandings of aging, gender, marriage, emotion work, and physical health problems in three primary ways. First, women do emotion work for their health-impaired husband, which is not surprising given past research, but our findings further reveal that women also do emotion work when they are health impaired themselves. Women’s emotion work is justified by the deployment of the view that caring for emotions is natural for women regardless of health status while needing emotional care typifies men. Emotion work done by a health-impaired wife for her husband alleviates the stress that husbands experience as a result of their wife’s own health impairment, yet this emotion work also adds to stress for the health-impaired wife. Second, some men do emotion work when their wife is health-impaired, but unlike women, men do not do emotion work during periods of their own health impairment. Emotion work is provided by men who see themselves as their wife’s primary source of stability and by men who conceptualize their marriage as balanced, whereas notions of traditional masculinity preclude some husbands from providing emotion work even when their wife is health-impaired. Third, wives and husbands do not always agree on who provides emotion work and why or gendered understandings of one another, demonstrating that gender relations within marriage are not only interactive but also contested and contentious. Taken together, these findings paint a portrait of gendered inequality in emotion work during periods of physical health problems.

Our findings highlight a significant and previously undocumented dimension of gender inequality by showing that women provide emotion work even when they experience their

own physical health problems. Past studies show that while health-impaired men adopt the “sick” role wherein they expect care from others and do not perform their typical daily duties, health-impaired women tend to avoid the sick role and continue to do their everyday unpaid work (Gove, 1984; Thomeer et al., 2013). We add to this body of work to highlight the emotion work done by wives when they are health-impaired. The danger, as Gove (1984) and others (Thomeer et al., 2013) speculate, is that health-impaired women’s emphasis on promoting their husband’s well-being may undermine women’s physical and mental health (Gove, 1984; Thomeer et al., 2013). We argue that the provision of “natural” emotion work by women regardless of women’s own health status, coupled with the relative lack of men’s corresponding emotion work helps us to better understand why the mental, emotional, and physical consequences of having a health-impaired spouse are more detrimental to the health and well-being of women compared to men (Pinquart & Sorensen, 2006; Vitaliano, Zhang, & Scanlan, 2003).

Past work has focused almost exclusively on emotion work provided by women to men and has not explicitly examined emotion work performed by men for a health-impaired spouse. Men’s provision of emotion work during periods of a wife’s health problems reveals that in some cases men challenge gendered norms concerning the division of emotion work. This finding corresponds with work in feminist gerontology that highlights the systematic occurrence of caregiving by older men (Calasanti & Bowen, 2006; King & Calasanti, 2013). However, men’s explanation for why they provide emotion work is indicative of adherence to traditional gendered notions of self (e.g., role as husband; see also Ribeiro, Paúl, & Nogueira, 2007). The limited scope of men’s provision of emotion work around physical health problems ultimately reinforces gender norms in mid- to later-life marriages.

This study is novel in that it focuses on how men and women discuss not only their own but also their spouse’s emotion work; this dyadic approach allows us to compare and contrast accounts to develop more sophisticated theoretical understandings of marital dynamics. Past studies focus on how either wives or husbands describe their own emotion work or caregiving (Hepburn et al., 2002; Kirsí et al., 2000), failing to consider how dyad members’ perspectives do or do not align. We find that husbands and wives generally agree on when and why women do emotion work around physical health problems as well as men’s need for emotion work. There is, however, spousal discordance in the perceptions and conceptualizations of men’s emotion work and the needs of health-impaired women (e.g., whether or not women are weak and in need of protection from husbands). Gender scripts appear to be upheld more by men than by women with possible costs for women and benefits for men’s emotional and physical health; this finding is in line with gender relations theory that articulates men as more invested in preserving their own gender status while women have more flexibility (Connell, 2005; Schippers, 2007). Our dyadic approach demonstrates the importance of using multiple perspectives in order to examine gender relations within marriage.

Limitations and conclusion

Despite the unique insight provided by examining emotion work in the context of physical health problems using a dyadic qualitative design, several limitations should be noted. These

limitations provide an important blueprint for future research in this area. First, our study was limited by the homogeneity of the sample in terms of race and ethnicity. Gender differences in giving, receiving, and interpreting emotion work may vary by race and ethnicity, though this has not been systematically studied. Second, the analysis examined couples in which one or both spouses labeled themselves as having a physical health problem. Results may have differed if we utilized a different operationalization of physical health, such as an official diagnosis or period of hospitalization. Third, we were not able to compare couples with physical health problems to couples without physical health problems because only couples with health problems were asked questions about how emotion work was provided in the context of illness. Future studies should compare emotion work in marriages where one spouse does, or does not, have a physical illness or use longitudinal data following couples before and during physical health problems to examine emotion work and gendered dynamics. Fourth, we interviewed spouses separately in order to preserve individual accounts of similar events—we were interested in comparing how husbands and wives described their feelings and perceptions around experiences in their marriage without being influenced by what their spouse thought (Reczek, 2014). However, future research should interview spouses together to examine how couples co-construct their understandings of emotion work around physical health problems.

Considering other ages and cohorts is an additional and interesting possibility for future research. Our analysis focuses on men and women in mid- to later-life who are more likely to have confronted physical health problems and may be characterized by more traditional gender dynamics than younger adults (Brewster & Padavic, 2000; Davis & Greenstein, 2009). It is likely that the dynamics of emotion work around physical health problems will be different at younger ages and for more recent cohorts. The nature of physical health problems and their care is changing. Certain chronic conditions (e.g., diabetes) are on the rise and diagnoses of these conditions are occurring at earlier ages (Hung et al., 2011; Ward, 2013); therefore, individuals are more likely to enter marriage with these conditions preexisting rather than receiving the diagnosis later in their marriage. This may alter the dynamics of emotion work around that condition. At the same time, people are entering marriages at older ages than in the past (Kreider & Ellis, 2011). Both of these trends may contribute to more independence in physical and emotional care for physical health problems, perhaps leading to less emotion work in general regardless of gender. Additionally, more egalitarian gender norms in cohabiting and marital relationships may also lead to fewer gender disparities in emotion work around physical health problems. Younger cohorts also have more diverse forms of intimate partnerships, including an increased number of same-sex and cohabiting households. Future studies should consider how emotion work operates during periods of physical health problems among same-sex couples and cohabiting couples, as it is likely that gender operates differently across these groups.

In her seminal piece on emotional labor in the paid work force, Hochschild (2003) argued that the emotional component of service workers' labors was often ignored and underappreciated. We extend this work by suggesting that emotion work during periods of physical health problems is also often overlooked, especially when provided by the health-impaired spouse. To ignore emotion work is to miss what many spouses themselves describe

as one of the most stressful aspects of having a spouse with a physical health problem or even being a health-impaired spouse and to overlook an important dimension of gendered inequality in marriage of mid-to later-life. In future research, scholars should work to highlight circumstances that upset and reinforce constructions of gender and regimes of unpaid work in marriage, particularly around physical health problems. As our findings demonstrate, such an examination helps us to understand the factors that sustain and exacerbate the (re)production of gender difference within heterosexual marriage that may contribute to emotional and physical health, while also introducing possibilities for disrupting these dynamics and introducing greater gender equality.

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Appendix A

Wife's name Husband's name	Age at interview (years)	Number of years married	Physical health problems	Education level	Race/ethnicity	Household income (thousands)	Employment status
Jane	63	36	Cancer	High school	White	Did not know	Homemaker
Richard	64		High blood pressure (hospitalized); vertigo	College	White	30–39	Retired
Kinsey	43	51	Appendicitis	College	White	80 or more	Full time
Robert	51		Knee surgery	Some college	White	80 or more	Full time
Katherine	72	50	Breast cancer (double mastectomy); heart problems (stint)	Advanced degree	White	40–59	Retired
Bill	73		Heart problems (bypass surgery)	College	White	30–39	Retired
Helen	77	36	Hysterectomy; congestive heart failure; broken collar bone	College	White	25–29	Retired
Wendell	78		Cancer; heart disease	Some high school	White	15–19	Retired
Mary	60	32	Sleep apnea	Advanced degree	Black	80 or more	Full time
Harold	61		Diabetes	College	Black	60–79	Part time
Valerie	42	12	Broken ankle	College	White	60–79	Homemaker
Keith	38		Migraines	Some college	white	40–59	Full time
Doris	68	36	Arthritis; broken hand and wrist; cancer; heart problems	College	White	40–59	Homemaker
Malcolm	72	–		Advanced degree	White	60–79	Part time
Christine	44	23	Broken ankle; hysterectomy; endometriosis	Advanced degree	White	60–79	Full time
Phil	49	–		college	White	80 or more	Full time
Angie	34	10	High cholesterol, high triglycerides; anemia	College	White	80 or more	Full time
Brett	35		Diabetes; heart condition	College	White	80 or more	Full time
Sasha	30	11	Heart problems; ovarian cyst	Associate degree	White	80 or more	Homemaker
Joel	31	–		College	White	60–79	Full time
Judy	70	47	–	College	White	Not reported	Homemaker
Ron	72		Cancer; heart problems	College	White	10–14	Retired
Carrie	39	12	Epilepsy; brain surgery	Advanced degree	Asian	25–29	Full time
Bruce	41	–		Some college	White	30–39	Self employed
Barbara	78	51	Gall bladder surgery, hysterectomy, partial paralysis	High school	White	60–79	Retired
Lou	81		Prostate cancer; heart problems	High school	White	60–79	Retired

Wife's name Husband's name	Age at interview (years)	Number of years married	Physical health problems	Education level	Race/ethnicity	Household income (thousands)	Employment status
Janna	54	9	Parkinson's disease; Lyme disease	Advanced degree	White	40–59	Full time
Rick	64		Spinal injury and surgery	Advanced degree	White	40–59	Full time
Tonya	34	9	Asthma	Some college	Black	40–59	Self employed
Aubrey	35		–	Advanced degree	Black	40–59	Part time
Pam	60	41	Arthritis; hip replacements; hysterectomy; bladder surgery	Some college	White	30–39	Part time
Steven	67		Broken ankle	Advanced degree	White	40–59	Retired
Gwen	52	8	Cancer; osteoporosis	Not reported	White	40–59	Full time
Hal	50		Cancer	Advanced degree	White	40–59	Unemployed
Nina	50	8	Asthma	Some college	Multiracial	10–14	Disabled
Lloyd	75		Heart disease (surgery); stroke; shingles	High school	White	Not reported	Unemployed
Tracy	49	26	–	Some college	White	15–19	Part time
Frank	53		Kidney stones; eye surgery	Some college	White	Below 10	Retired
Louise	35	18	Cancer	College	White	60–79	Full time
Jake	39		Collapsed lung	College	White	60–79	Full time
Jean	77	40	Osteoporosis	Advanced degree	White	40–59	Retired
Howard	87		Early Alzheimer's; heart problems; anemia; cancer	Some college	White	10–14	Retired